**INFORMED CONSENT: COVID-19 VACCINATION 2021**

LSU Health NEW ORLEANS

| Last Name: (Print) | First Name: | Middle: | DOB: | Age: |
|---|---|---|---|---|
| Phone (include area code): | | Cell Phone (include area code): | | |
| Address: | City: | State: | Zip: | |

Nursing ☐ Medicine ☐ Dentistry ☐ Allied Health ☐ Public Health ☐
Faculty ☐ Staff ☐ Student ☐ Graduate Studies ☐
LSUHN Staff ☐ Other_____

| CHECK **ANY THAT APPLY** AND **NOTIFY THE NURSE PRIOR TO ADMINISTRATION** | | |
|---|---|---|
| | **YES** | **NO** |
| Are you experiencing any COVID-like symptoms including but not limited to fever (>100.0), shortness of breath, dry cough, runny nose, sore throat, muscle pain, or loss of taste or smell? | ☐ | ☐ |
| Have you been diagnosed with any of the following conditions?<br>• HIV infection<br>• Immunosuppression (weakened immune system)<br>• Autoimmune conditions | ☐ | ☐ |
| Have you received monoclonal antibodies or convalescent plasma for treatment of COVID-19 infection in the past 90 days? | ☐ | ☐ |
| Have you received a dose of the Covid-19 vaccine before? | ☐ | ☐ |
| Have you received any vaccinations in the past 14 days? | ☐ | ☐ |
| **For women:** Are you pregnant or breastfeeding or is there a chance you could become pregnant during the next month? | ☐ | ☐ |
| Do you have a significant history of allergic reactions to vaccines, medicine, or food, such as an anaphylactoid reaction, or have you been advised to carry an adrenaline autoinjector with you (EpiPen)? | ☐ | ☐ |
| **If you answered yes to any of the questions above, you may want to speak with your physician before receiving the vaccine.** | | |

I have received *Emergency Use Authorization of the COVID-19 Vaccine Fact Sheet for Recipients and Caregivers* about the COVID-19 vaccine and have had chance to ask questions and had them answered to my satisfaction.

- I understand that the common side effects for adults include soreness and redness at the injection site, fever, muscle aches, headaches, and tiredness.
- I have read the information provided on this form, and I have answered all questions honestly.
- I give my permission to release this COVID-19 documentation to other medical care providers to avoid unnecessary vaccinations and to determine immunization status.
- I understand that I am to wait **15 – 30 minutes** after receiving the COVID-19 vaccine before leaving the building.
- As recommended, I have discussed any situation (and others) listed above with my healthcare provider and agree to proceed with the COVID-19 vaccination.
- **I understand the benefits and risks of the COVID-19 vaccine and I hereby authorize and consent to receive the vaccination.**

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LSU Health NEW ORLEANS

**I GIVE CONSENT** to Louisiana State University Health Sciences Center New Orleans (LINKS Organization ID #1680) to vaccinate me for the COVID-19 virus.

***I also agree to allow information about all vaccinations given to me or to the person for whom I am authorized to consent to be release to other medical care providers or schools to avoid the administration of unnecessary vaccinations and to determine immunization status. I understand this will remain in effect until canceled by me in writing.***

SIGNATURE: _____ Date: _____

## FOR OFFICE USE ONLY:

| VACCINE NAME: | IMMUNIZATION LOT# & EXPIRATION DATE | DOSE GIVEN | INJECTION SITE/ROUTE | DATE | TIME | VACCINE ADMINISTRATOR SIGNATURE |
|---|---|---|---|---|---|---|
| **COVID-19** | Lot #: EL3247 | | **R / L** | | | |
| **Manufacturer:** | Exp: 05/2021 | | | | | |
| Pfizer | | | **IM** | | | |